

WHO/PBL EYE EXAMINATION RECORD FOR CHILDREN WITH BLINDNESS AND LOW VISION

A.1 CENSUS BLIND SCHOOL / HOSPITAL STUDIES

Country No. School/Hospital No. Child No.

(1-3) (4-5) (6-8)

School/ Hospital _____

A.2 CENSUS POPULATION BASED SURVEYS

Country No. Cluster No.

(1-3) (4-6)

Household No. Child No.

(7-9) (10-11)

B. PERSONAL DETAILS OF CHILD

Name: _____

Home Town/Village: _____

Ethnic Group: _____

Age: In months (0-1 yr olds) Sex: Male = 1
(12-13) (16) Female = 2

In years (1-15 yr olds)
(14-15)

Age at onset of visual loss: Family history: Is there a family history of the same condition?
(17-18) 00 Since birth 1 Yes
88 First Year of life 2 No
01-15 in Years 3 Unknown
99 Unknown (19)

If yes, who is similarly affected? _____

Consanguinity: 1 Yes
Is there a history of consanguinity? 2 No
3 Unknown (20)

C. VISUAL ASSESSMENT

1) Distance vision: With present glasses 1
Unaided 2
(21)

Test each eye separately, then together.

	Right	Left	Right & Left
6/6 - 6/18	<input type="checkbox"/> 1	<input type="checkbox"/>	<input type="checkbox"/>
less than 6/18 - 6/60	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
less than 6/60 - 3/60	<input type="checkbox"/> 3	<input type="checkbox"/>	<input type="checkbox"/>
less than 3/60 - PL	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
No light perception	<input type="checkbox"/> 5	<input type="checkbox"/>	<input type="checkbox"/>
Cannot be tested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
believed sighted	<input type="checkbox"/> 6	<input type="checkbox"/>	<input type="checkbox"/>
believed blind	<input type="checkbox"/> 7	<input type="checkbox"/>	<input type="checkbox"/>

(22) (23) (24)

2) Functional vision: Test with both eyes together

	Yes	No	Not Tested
Can see to walk around (25)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Can recognise faces (26)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can see print (27)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Believed useful residual vision (28)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3) Visual Fields Test each eye separately

	Right	Left
Full field	<input type="checkbox"/> 1	<input type="checkbox"/>
Hemianopia	<input type="checkbox"/> 2	<input type="checkbox"/>
Constricted to less than 10°	<input type="checkbox"/> 3	<input type="checkbox"/>
Other field loss	<input type="checkbox"/> 4	<input type="checkbox"/>
Cannot test	<input type="checkbox"/> 5	<input type="checkbox"/>
Not tested	<input type="checkbox"/> 6	<input type="checkbox"/>
Specify type of test (29)	<input type="checkbox"/>	<input type="checkbox"/> (30)

D. GENERAL ASSESSMENT

Additional disability Tick all that apply

None (31)

Hearing loss (32)

Mental retardation (33)

Physical handicap (34)

Epilepsy (35)

Other (36)

Specify _____

E. PREVIOUS EYE SURGERY

Tick all that apply

	Right	Left
None	(37) <input type="checkbox"/>	(38) <input type="checkbox"/>
Glaucoma	(39) <input type="checkbox"/>	(40) <input type="checkbox"/>
Cataract	(41) <input type="checkbox"/>	(42) <input type="checkbox"/>
Corneal Graft	(43) <input type="checkbox"/>	(44) <input type="checkbox"/>
Optical Iridectomy	(45) <input type="checkbox"/>	(46) <input type="checkbox"/>
Removed	(47) <input type="checkbox"/>	(48) <input type="checkbox"/>
Surgery, type unknown	(49) <input type="checkbox"/>	(50) <input type="checkbox"/>
Other, Specify	(51) <input type="checkbox"/>	(52) <input type="checkbox"/>

Please give full details including dates, if available,

Right eye _____ Left eye _____

F. EYE EXAMINATION - Site of ABNORMALITY leading to VISUAL LOSS

For each eye mark one major abnormality and all others that contribute to visual loss

	Right Eye		Left Eye	
	Major	Others	Major	Others
Whole globe: (53)			(89)	
Phthisis	<input type="checkbox"/> 1	<input type="checkbox"/> (54)	<input type="checkbox"/> 1	<input type="checkbox"/> (90)
Anophthalmos	<input type="checkbox"/> 2	<input type="checkbox"/> (55)	<input type="checkbox"/> 2	<input type="checkbox"/> (91)
Microphthalmos	<input type="checkbox"/> 3	<input type="checkbox"/> (56)	<input type="checkbox"/> 3	<input type="checkbox"/> (92)
Buphthalmos	<input type="checkbox"/> 4	<input type="checkbox"/> (57)	<input type="checkbox"/> 4	<input type="checkbox"/> (93)
Glaucoma	<input type="checkbox"/> 5	<input type="checkbox"/> (58)	<input type="checkbox"/> 5	<input type="checkbox"/> (94)
Removed	<input type="checkbox"/> 6	<input type="checkbox"/> (59)	<input type="checkbox"/> 6	<input type="checkbox"/> (95)
Disorganised	<input type="checkbox"/> 7	<input type="checkbox"/> (60)	<input type="checkbox"/> 7	<input type="checkbox"/> (96)
Other	<input type="checkbox"/> 8	<input type="checkbox"/> (61)	<input type="checkbox"/> 8	<input type="checkbox"/> (97)
Cornea:				
Staphyloma	<input type="checkbox"/> 9	<input type="checkbox"/> (62)	<input type="checkbox"/> 9	<input type="checkbox"/> (98)
Scar	<input type="checkbox"/> 10	<input type="checkbox"/> (63)	<input type="checkbox"/> 10	<input type="checkbox"/> (99)
Keratoconus	<input type="checkbox"/> 11	<input type="checkbox"/> (64)	<input type="checkbox"/> 11	<input type="checkbox"/> (100)
Dystrophy	<input type="checkbox"/> 12	<input type="checkbox"/> (65)	<input type="checkbox"/> 12	<input type="checkbox"/> (101)
Other Opacity	<input type="checkbox"/> 13	<input type="checkbox"/> (66)	<input type="checkbox"/> 13	<input type="checkbox"/> (102)
Lens:				
Cataract	<input type="checkbox"/> 14	<input type="checkbox"/> (67)	<input type="checkbox"/> 14	<input type="checkbox"/> (103)
Aphakia	<input type="checkbox"/> 15	<input type="checkbox"/> (68)	<input type="checkbox"/> 15	<input type="checkbox"/> (104)
Other	<input type="checkbox"/> 16	<input type="checkbox"/> (69)	<input type="checkbox"/> 16	<input type="checkbox"/> (105)
Uvea:				
Anidria	<input type="checkbox"/> 17	<input type="checkbox"/> (70)	<input type="checkbox"/> 17	<input type="checkbox"/> (106)
Coloboma	<input type="checkbox"/> 18	<input type="checkbox"/> (71)	<input type="checkbox"/> 18	<input type="checkbox"/> (107)
Uveitis	<input type="checkbox"/> 19	<input type="checkbox"/> (72)	<input type="checkbox"/> 19	<input type="checkbox"/> (108)
Other	<input type="checkbox"/> 20	<input type="checkbox"/> (73)	<input type="checkbox"/> 20	<input type="checkbox"/> (109)
Retina:				
Dystrophy	<input type="checkbox"/> 21	<input type="checkbox"/> (74)	<input type="checkbox"/> 21	<input type="checkbox"/> (110)
Albinism	<input type="checkbox"/> 22	<input type="checkbox"/> (75)	<input type="checkbox"/> 22	<input type="checkbox"/> (111)
ROP	<input type="checkbox"/> 23	<input type="checkbox"/> (76)	<input type="checkbox"/> 23	<input type="checkbox"/> (112)
Retinoblastoma	<input type="checkbox"/> 24	<input type="checkbox"/> (77)	<input type="checkbox"/> 24	<input type="checkbox"/> (113)
Other	<input type="checkbox"/> 25	<input type="checkbox"/> (78)	<input type="checkbox"/> 25	<input type="checkbox"/> (114)
Optic Nerve:				
Atrophy	<input type="checkbox"/> 26	<input type="checkbox"/> (79)	<input type="checkbox"/> 26	<input type="checkbox"/> (115)
Hypoplasia	<input type="checkbox"/> 27	<input type="checkbox"/> (80)	<input type="checkbox"/> 27	<input type="checkbox"/> (116)
Other	<input type="checkbox"/> 28	<input type="checkbox"/> (81)	<input type="checkbox"/> 28	<input type="checkbox"/> (117)
Other, not listed	<input type="checkbox"/> 29	<input type="checkbox"/> (82)	<input type="checkbox"/> 29	<input type="checkbox"/> (118)
Globe appears normal (complete after refraction see Section G)				
Refractive error	<input type="checkbox"/> 30	<input type="checkbox"/> (83)	<input type="checkbox"/> 30	<input type="checkbox"/> (119)
Amblyopia	<input type="checkbox"/> 31	<input type="checkbox"/> (84)	<input type="checkbox"/> 31	<input type="checkbox"/> (120)
Cortical blindness	<input type="checkbox"/> 32	<input type="checkbox"/> (85)	<input type="checkbox"/> 32	<input type="checkbox"/> (121)
Idiopathic nystagmus	<input type="checkbox"/> 33	<input type="checkbox"/> (86)	<input type="checkbox"/> 33	<input type="checkbox"/> (122)
Normal vision	<input type="checkbox"/> 34	<input type="checkbox"/> (87)	<input type="checkbox"/> 34	<input type="checkbox"/> (123)
Not examined	<input type="checkbox"/> 99	(88a)	<input type="checkbox"/> 99	(88b)

THE MAJOR SITE OF ABNORMALITY LEADING TO VISUAL LOSS FOR THE CHILD (124)

SELECT RIGHT OR LEFT EYE Right Left

G. REFRACTION /LOW VISION AID ASSESSMENT

	Yes	No	Not indicated	Not done
Vision improves with a pinhole	1 <input type="checkbox"/> (125) <input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
Refraction performed now	1 <input type="checkbox"/> (126) <input type="checkbox"/> 2			
Vision assessed with low vision aid	1 <input type="checkbox"/> (127) <input type="checkbox"/> 2	<input type="checkbox"/> 3		

1) If refraction performed, visual acuity with corrective lenses:

Distance: Test each eye separately, then together

	Right	Left	Right & Left
6/5 - 6/18	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
less than 6/18 - 6/60	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
less than 6/60 - 3/60	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
less than 3/60	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

(128) (129) (130)

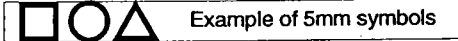
Specify corrective lenses and visual acuity

Right eye ----- VA -----

Left eye ----- VA -----

Near: Test with both eyes together

Can discern print /symbols equal to or smaller than 5mm ($\leq 5\text{mm}$) (131) 1 2



2) If assessed with low vision aid (LVA), visual acuity with LVA

Distance: Specify type of LVA and visual acuity

Right eye ----- VA -----

Left eye ----- VA -----

Near: Specify type of LVA and near acuity

Right eye ----- VA -----

Left eye ----- VA -----

	Right	Left
Can discern print $\leq 5\text{mm}$	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Can discern print $> 5\text{mm}$	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cannot discern print	<input type="checkbox"/> 3	<input type="checkbox"/> 4

(132) (133)

H. EYE EXAMINATION - AETIOLOGY OF VISUAL LOSS

Select one of the categories 1-5 for each eye
Tick all that apply within the selected category.

		Right eye		Left eye	
		Definite	Suspect	Definite	Suspect
1) Hereditary Disease:	Chromosomal	(134) <input type="checkbox"/> 1	<input type="checkbox"/> 2	(135) <input type="checkbox"/> 1	<input type="checkbox"/> 2
	Mitochondrial	(136) <input type="checkbox"/>	<input type="checkbox"/>	(137) <input type="checkbox"/>	<input type="checkbox"/>
	Autosomal dominant	(138) <input type="checkbox"/>	<input type="checkbox"/>	(139) <input type="checkbox"/>	<input type="checkbox"/>
	Autosomal recessive	(140) <input type="checkbox"/>	<input type="checkbox"/>	(141) <input type="checkbox"/>	<input type="checkbox"/>
	X-linked	(142) <input type="checkbox"/>	<input type="checkbox"/>	(143) <input type="checkbox"/>	<input type="checkbox"/>
	Cannot Specify	(144) <input type="checkbox"/>		(145) <input type="checkbox"/>	
2) Intrauterine factor:	Rubella	(146) <input type="checkbox"/> 1	<input type="checkbox"/> 2	(147) <input type="checkbox"/> 1	<input type="checkbox"/> 2
	Toxoplasmosis	(148) <input type="checkbox"/>	<input type="checkbox"/>	(149) <input type="checkbox"/>	<input type="checkbox"/>
	Drugs / alcohol	(150) <input type="checkbox"/>	<input type="checkbox"/>	(151) <input type="checkbox"/>	<input type="checkbox"/>
	Other, Specify	(152) <input type="checkbox"/>	<input type="checkbox"/>	(153) <input type="checkbox"/>	<input type="checkbox"/>
3) Perinatal/ Neonatal factor:	Cerebral hypoxia /injury	(154) <input type="checkbox"/> 1	<input type="checkbox"/> 2	(155) <input type="checkbox"/> 1	<input type="checkbox"/> 2
	R.O.P.	(156) <input type="checkbox"/>	<input type="checkbox"/>	(157) <input type="checkbox"/>	<input type="checkbox"/>
	Ophthalmia neonatorum	(158) <input type="checkbox"/>	<input type="checkbox"/>	(159) <input type="checkbox"/>	<input type="checkbox"/>
	Other, Specify	(160) <input type="checkbox"/>	<input type="checkbox"/>	(161) <input type="checkbox"/>	<input type="checkbox"/>
4) Postnatal/ Infancy/ Childhood factor:	Vitamin A deficiency	(162) <input type="checkbox"/> 1	<input type="checkbox"/> 2	(163) <input type="checkbox"/> 1	<input type="checkbox"/> 2
	Measles	(164) <input type="checkbox"/>	<input type="checkbox"/>	(165) <input type="checkbox"/>	<input type="checkbox"/>
	Neoplasm	(166) <input type="checkbox"/>	<input type="checkbox"/>	(167) <input type="checkbox"/>	<input type="checkbox"/>
	Trauma	(168) <input type="checkbox"/>	<input type="checkbox"/>	(169) <input type="checkbox"/>	<input type="checkbox"/>
	Harmful Trad. Practices	(170) <input type="checkbox"/>	<input type="checkbox"/>	(171) <input type="checkbox"/>	<input type="checkbox"/>
	Other, Specify	(172) <input type="checkbox"/>	<input type="checkbox"/>	(173) <input type="checkbox"/>	<input type="checkbox"/>
5) Cannot determine (unknown aetiology))	Cataract	(174) <input type="checkbox"/>		(175) <input type="checkbox"/>	
	Glaucoma / Buphthalmos	(176) <input type="checkbox"/>		(177) <input type="checkbox"/>	
	Retinoblastoma, no FH	(178) <input type="checkbox"/>		(179) <input type="checkbox"/>	
	Abnormality since birth	(180) <input type="checkbox"/>		(181) <input type="checkbox"/>	
	Other, Specify	(182) <input type="checkbox"/>		(183) <input type="checkbox"/>	

THE MAIN AETIOLOGY OF VISUAL LOSS FOR THE CHILD

SELECT ONE FROM POSITIONS 134-183 [] (184)

I. ACTION NEEDED

1) Optical Tick all that apply

None (185)

Refraction later (186)

Spectacles (187)

Low vision aid (188)

2) Medical / Surgical Tick all that apply

None (189)

Medication (190)

Surgery (191)

Specify -----

Other (192)

Specify -----

J. PROGNOSIS FOR VISION

Tick one box only for each eye

	Right eye	Left eye
Could be improved	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Likely to remain stable	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Likely to deteriorate	<input type="checkbox"/> 3	<input type="checkbox"/> 3

(193) (194)

K. EDUCATION

1) Present schooling Tick one box only

Special school for the blind 1

Special school for the multiply handicapped 2

Integrated education 3

None 4

Other 5

Specify (195) -----

2) Recommendations:

Change in schooling recommended (196) YES NO

Specify -----

L. FULL DIAGNOSIS

Specify full anatomical and aetiological diagnosis:

Right eye:

Left eye:

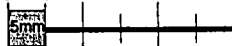
M. EXAMINER:

Examined by

Date (month) (year)

(197-200)

mm 0 5 10 15 20 25 30



WHO/PBL EYE EXAMINATION RECORD

A. CENSUS

Country No. (1-3) Study No. (4-5) Date (6-9) Admin. Division (10-11) Cluster (12-13) Household (14-15) Person (16-17)

Name Age (18-19) Male 1. Female 2. Optional (21-25) Exam Status (26)

B. VISION

Unaided - or 0. With Glasses 1. (27)

(28) R L (29)

CAN BE TESTED: Can see 6/18 (0.3) 1.

LOW VISION [cannot see 6/18 (0.3)] 2. [can see 6/60 (0.1)]

[cannot see 6/60 (0.1)] 3. [can see 3/60 (0.05)]

BLIND [cannot see 3/60 (0.05)] 4.

CANNOT BE TESTED: BELIEVED BLIND * 5. BELIEVED NOT BLIND 6.

REFRACTION (optional) R L Low vision or blindness improves with pinhole or lens to 6/18 or better (30) (31)

C. BASIC EYE EXAMINATION

NO LISTED ABNORMALITY (32) R L (33)

ABNORMALITY (all which apply):

EYELID Inturned margin/trichiasis (34) (35)

GLOBE Phthisical/disorganized/absent (36) (37)

CORNEA Central corneal opacity (38) (39) Pterygium (corneal) (40) (41)

LENS NO VIEW OF LENS (42) (43) Obvious opacity (44) (45) Aphakia (46) (47)

OTHER * Specify (48) (49) NOT EXAMINED (50) (51)

D. PREVIOUS EYE SURGERY

NO EVIDENCE OF SURGERY (52)

TYPE OF PREVIOUS SURGERY:

Eyelid (53) Cataract (54) Glaucoma (55) Couching (56) Other * (57) NOT ASSESSED (58)

E. ADDITIONAL EXAMS (optional):

XEROPHTHALMIA

NO LISTED SIGN (59)

SIGNS OF XEROPHTHALMIA: Night Blindness (60) Bitot's spots (61) Corneal xerosis (62) NOT EXAMINED (63)

TRACHOMA

NO LISTED SIGN (64) R L (65)

SIGN OF TRACHOMA: TF (66) (67) TI (68) (69) TC (70) (71) NOT EXAMINED (72) (73)

INTRAOCULAR PRESSURE

IOP in mm Hg. (74-75) (76-77) NOT EXAMINED (78) (79)

OPTIONAL EXAMINATION

(80) (81) NOT EXAMINED (82) (83)

SCREENING EXAMINER REMARKS (all *'s): _____ SCREENING EXAMINER No. (84-85)

F. CAUSES OF LOW VISION OR BLINDNESS

FOR EACH EYE: MARK ALL WHICH APPLY

DISORDERS:

Phthisical, Disorganized or Absent Globe	(86) <input type="checkbox"/> R <input type="checkbox"/> L (87)
Refractive Error	(88) <input type="checkbox"/> R <input type="checkbox"/> L (89)
Cataract	(90) <input type="checkbox"/> R <input type="checkbox"/> L (91)
Uncorrected Aphakia	(92) <input type="checkbox"/> R <input type="checkbox"/> L (93)
Trachomatous Corneal Opacity	(94) <input type="checkbox"/> R <input type="checkbox"/> L (95)
Other Corneal Opacity *	(96) <input type="checkbox"/> R <input type="checkbox"/> L (97)
Anterior Uveitis	(98) <input type="checkbox"/> R <input type="checkbox"/> L (99)
Glaucoma	(100) <input type="checkbox"/> R <input type="checkbox"/> L (101)
Optic Atrophy	(102) <input type="checkbox"/> R <input type="checkbox"/> L (103)
Vascular Retinopathy	(104) <input type="checkbox"/> R <input type="checkbox"/> L (105)
Chorioretinitis	(106) <input type="checkbox"/> R <input type="checkbox"/> L (107)
Macular Degeneration	(108) <input type="checkbox"/> R <input type="checkbox"/> L (109)
Other *	(110) <input type="checkbox"/> R <input type="checkbox"/> L (111)
NOT EXAMINED	(112) <input type="checkbox"/> R <input type="checkbox"/> L (113)

UNDERLYING CAUSES: MARK ALL WHICH APPLY

No listed underlying cause	(114) <input type="checkbox"/> (115)
Trauma	(116) <input type="checkbox"/> (117)
Congenital/Neonatal Factor	(118) <input type="checkbox"/> (119)
Onchocerciasis	(120) <input type="checkbox"/> (121)
Measles/Vit. A Deficiency	(122) <input type="checkbox"/> (123)
Surgical Procedure	(124) <input type="checkbox"/> (125)
Couching	(126) <input type="checkbox"/> (127)
OPTIONAL FACTOR	(128) <input type="checkbox"/> (129)

FOR THE PERSON: MARK ONLY ONE PRINCIPAL DISORDER

1. (130)
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
88.
99.

PRINCIPAL CAUSE MARK ONLY ONE

0. (131)
1.
2.
3.
4.
5.
6.
7.

G. CURRENT ACTION NEEDED

NO CURRENT ACTION NEEDED (132) (133)

ACTION NEEDED (All which apply):

Eyelid surgery	(134) <input type="checkbox"/> (135)
Cataract surgery	(136) <input type="checkbox"/> (137)
Glaucoma treatment	(138) <input type="checkbox"/> (139)
Spectacles	(140) <input type="checkbox"/> (141)
Medication	(142) <input type="checkbox"/> (143)
Other *	(144) <input type="checkbox"/> (145)

SPECIAL EXAMINER No. (146-147)

SPECIAL EXAMINER REMARKS (All *'s): _____